# HIT Quality Measures Workgroup
# Draft Transcript
# April 12, 2011

## Presentation

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Good morning, everybody, and welcome to the Policy Committee's Quality Measures Workgroup. This is a FACA Committee, so there will be opportunity at the end of the call for the public to make comment, and a reminder to workgroup members to please identify yourselves when speaking so we can have attribution. A quick roll call: David Lansky?

**David Lansky – Pacific Business Group on Health – President & CEO**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Paul Tang?

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Neil Calman? Eva Powell?

**Eva Powell – National Partnership for Women & Families – Director IT**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Marc Overhage?

**Marc Overhage – Regenstrief – Director**
Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Carol Diamond? Peter Basch? Bob Kocher? Jacob Reider? I know he was on. Karen Kmetik?

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**
I'm here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Jesse Singer? Tim Ferris? Laura Petersen?

**Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Jim Walker?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Paul Wallace? Joachim Roski?

**Joachim Roski – Engelberg Center for Health Care Reform – Research Director**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Helen Burstin?

**Helen Burstin – NQF – Senior VP, Performance Measures**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
David Kendrick? Patrick Gordon? Sarah Scholle? Russ Branzell?

**Russ Branzell – Poudre Valley Health System – CIO**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Tripp Bradd?

**Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Charles Kennedy? Norma Lang?

**Norma Lang – University of Wisconsin and American Nurses Association**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Jon White?

**Jon White AHRQ/HHS – Director IT**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
David Baker?

**David Baker – Northwestern – Chief, General Internal Medicine Division**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Dan Green?

**Daniel Green – CMS/HHS – Medical Director**
Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Who else is on the line? Did I miss anyone?

**Neil Calman – Institute for Family Health – President & Cofounder**
It's Neil. I had my phone on mute. It's Neil Calman.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Okay, thank you. Anyone else?

**M**

Jacob ... with Family Doctors .... Sorry, Judy.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Thank you. I'll turn it over to David Lansky.

**David Lansky – Pacific Business Group on Health – President & CEO**
Thanks, Judy, and thank you all for making time to reconvene. We had a pretty intense burst of work last fall and winter and then we got a little time to catch our breath, and now here we go again. I think the challenge we left ourselves were several important strategic and structural issues around the measurement approach of meaningful use. As we look at winter to get out the first batch of new measures out to the measurement development world, we put out in the parking lot a number of issues that we knew we'd have to come back to that would take some deliberation and really had some policy implications. Today I think is meant to be a sort of stage setting for the several months ahead, where what we'd like to do is get your perspective and input on some of the structural and strategic approaches we want to take to the next round of quality measures, and we'll go through a few key issues today.

What we'd like to do is remind ourselves of how to state what requirements were defined, including some of the challenges we had in thinking about the core menu structure, and Paul, you can help us reflect back a little bit on the way the core measurement approach evolved during those discussions a year or so ago. And then think about how well that model applies for Stage 2 going forward, and whether we want to consider that structure, put that in the context of what's already been laid out by a number of committees around the Stage 2 approach and the principles for Stage 2, and most recently put it in the context of the National Quality Strategy that HHS has announced, which provides some principles and strategic direction and areas of focus that we may want to have included in our thinking about the way Stage 2 is expressed.

I think in all that we're all cognizant of the desire by HHS and certainly by the providers in the industry to harmonize the kinds of measures and measurement approaches and measurement methodologies so that people aren't being bombarded with variant and esoteric measurement requirements. But to the extent we can think of Stage 2 and Stage 3 as introducing some new measures that certainly fit with policy goals but also are concordant with what we're seeing on ACOs and the National Quality Strategy and other activities, including even today the new announcement on the patient pay through strategy. If we can align all this ... work I think it's a win for everybody.

Those are all the landscape factors that we want to keep in mind as we think about this today and try to chart our course going forward. So as a way of doing that, you'll see by the agenda that we're going to take you back in time and do a little review of Stage 1. And perhaps in the context of that we may want to think about what's the best way for us to get some input from the field about the experience of Stage 1 measurement reporting so far and then talk about the principles for Stage 2 National Quality Strategy. Ultimately, I think our goal is to see if we have clarity about the structure of the measurement reporting requirements going forward.

Also, I know you've seen the attachments in today's e-mail and we've been provided both the list of retooled measures that will be available, and we can use some of those measures to populate either a core or menu approach. And we also have the measurement concept that we all worked on ... for development work which could also be used to populate the core or the menu approach if we stay with that strategy. So we've got a lot of material in front of us, and I think the ... today is to synthesize it into some kind of a policy direction that we think is solid and we can then talk with the other committees about.

I might also ask, just by way of maybe a little commentary, Jim, if you're willing just to let people know what's happening on the Standards Committee side in beginning to look at some of the same issues that we have in front of us and talk just for a minute about harmonizing the work of the Clinical Quality Measures Workgroup on the Standards Committee with this committee. I don't know, Jim, I don't want to put you on the spot. We can do it a little bit later, if you want –

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
No, that's great, David. Just briefly, we're very interested in taking the measure concepts recommendations of this group and thinking through as carefully as we can what kinds of information needs and other requirements, standards, vocabulary sets will be needed to make those measures actionable. So it makes my participation on this group much more interesting to me than it was previously. I think, and I don't know if there will be an opportunity, I'm interested in asking this group some questions that arise, but what we're trying to do in the Clinical Quality Workgroup is identify the questions that ONC needs us to answer and a timeframe to get those done in so that we do it fast enough and completely enough that we can move the agenda forward.

**David Lansky – Pacific Business Group on Health – President & CEO**
Great. We actually just got started a week or so ago, so it was a good time for us to have some cross-fertilizing between the two groups as we go forward. I'm serving on another group and I think a couple of us on this call are in both groups.

With that, I don't know if I can ask Tom, if you're on now, to get us to this slide material and maybe reorient us to Stage 1.

**Tom**
Thanks, David, and thanks to all the members of this committee for taking time out to helping us think through this process. I just want to go over very quickly the Stage 1 requirements for the Clinical Quality Measures, at least on the ambulatory care side. We have a total of 44 that have been re-tooled or re-specified. Judy, can we have the second slide?

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Yes. Caitlin, can you move it forward, please?

**Tom**
As you can see, we have the core requirements, and there are 3 of them there; 3 alternate and there are 38 as part of the menu set. Next slide, please.

The three core, just to jog your memory, it's adult weight screening and follow up, and that's basically looking at the BMI; and the second one is calculation, looking at hypertension and blood pressure management. The third one is two parts. It's looking at tobacco use assessment, and then tobacco cessation intervention. If these measures, if the provider deemed them to be not within the scope of work, they can attest that they have a zero denominator and they can actually pick and choose measures from the alternate core group of measures, and they are the following: childhood immunization status, preventive care screening, looking at influenza immunization for patients greater than the age of 50, and then the weight assessment counseling for children and adolescents.

Again, the provider has the option to also attest that these three measures are not within the scope of work and they can get to put zero as part of the denominator and they can attest to that on the attestation tool that's out already. Then they have to select 3 measures from the set of 38 specialty related clinical quality measures as well. On the hospital side, there are 15 measures that the hospitals are required to do.

The next slide, I just want to remind everyone that the Stage 2 principles, and I think all of you are familiar with, as the last six months we've ... the work in terms of looking at priority areas for these five domain areas, looking at improving quality, safety, efficiency, and reducing health disparities, engaging patients and families, care coordination, and also looking at public health and population health. We also put down ensuring adequate privacy and security protections for PHI in here as a guiding principle as well. Those are the Stage 1 requirements for the ambulatory care side. I think Paul and many of you here were part of the discussion as you decide on some of the priority areas for Stage 1 and saw the outcomes of the discussion.

David and Paul, do you want to make some comments about some of the processes involved in terms of deciding the Stage 1 process and how we should look at the Stage 2 process?

**David Lansky – Pacific Business Group on Health – President & CEO**
I think it would be helpful. Paul, I was remembering a couple of meetings we had when we were assessing the core measures for meaningful use, and I think we had had some aspirations that we would have a longer set of core measures that would be generally applicable to most eligible professionals, and as we went through them one by one in a couple of sessions it was tough to get a lot of measures that we felt legitimately applied to a broad swath of providers. And I think we were all a little disappointed where we ended up. Also, Tom, I appreciate your comments from the experiential side of what you guys at ONC have been hearing during the Stage 1 implementation as far as the success of this model in helping providers report meaningful information and feel satisfied about the process. So I think a little round of discussion here, both about the way Stage1 works in producing a set of core measures and whatever implementation experience all of us had this year so far would be good to inform our thinking about Stage 2. Paul, do you have anything you want to share about how you remember the Stage 1 measurement process?

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
Sure. There was one overarching approach or philosophy we took. We had a branch point, do we put in something for everyone, that was the so-called 500 measure approach versus the salient few, and we chose to try to focus more on things that applied broadly and that would also go in the direction of our Stage 3 outcome goals. So that was our goal. How well we achieved it remains to be seen. But I think what we're saying is, well, when we did look, as David mentioned, so we tried to focus on a few core that would apply to everyone and in the end we couldn't find any. So it turns out our recommendation finally to CMS and ONC was that there wasn't the concept of core that literally applied to everyone. Now, they had an interesting way of keeping core but also letting it out of having attesting to a ... denominator. That was an interesting way to approach that.

In the process we found that there were few endorsed measures in the field that took advantage of this rich clinical data that's in EHR. So in some sense we prodded both the field and ONC and CMS to stimulate those kinds of outcomes oriented measures, measures that took advantage of the rich clinical data to be developed. I think that work actually is in process, both through contracts and through other discussions, moving the field along. I think we're in the transitory position, knowing that it takes time, maybe something like 18 months, to develop new measures, develop them and test them and submit for endorsement new measures, so that's where we find ourselves in between Stage 1, where we had to use existing measures that are simply retooled, to Stage 3 hopefully when there are better measures around. I would say that the field has suffered some of having fewer measures that apply to specialists, and that's, I think, something we have to deal with in this transitory stage.

But our goal is always to move measures in the direction of where we want to be both clinically, and now that health reform is upon us we want to move to better measures upon which we're going to be measured and paid. So I think that the Meaningful Use Workgroup is still of the mind that fewer good measures is a better direction than having lots of measures.

**David Lansky – Pacific Business Group on Health – President & CEO**
Tom, or others, do you have any reports in terms of what's happening in terms of field experience so far with the Stage 1 approach that we've put in play?

**Tom**
I think the measures that we've selected for Stage 1 have relevancy to certainly all the primary care physicians, and particularly internal medicine and family practice. We've been hearing, at least from the RACs and from the Beacon communities, some of the measures are actually truly foundational in terms of some of the overarching community health improvement bills that they want to engage in, particularly diabetes work and cardiovascular prevention work, and especially the BMI measure and the tobacco cessation measure. We've heard from comments from the specialists, particularly the interventional or procedure based specialties, such as interventional radiologists and ophthalmology perhaps and maybe

dermatology, and I think the Meaningful Use Committee is having a specialty meeting regarding some of these issues.

But I think for the most part, at least from our end applied to the priority providers ..., that's the target group for the RACs and a lot of the Beacons, it is extremely relevant and I think the measures that you saw here are as broad-based as possible considering what you've had to work with in terms of, as we were transitioning from a claims-based measure approach to these new measures where we're just starting to look at a standardized information model in terms of re-tooling these measures. I think for the next three years, as Paul said, we're going to need a certain amount of lead time to develop these innovative measures to take full advantage of the robust data. I think we've actually done quite well with the three core measures that we've selected. I think if we take into consideration the National Quality Strategy goals and some of the other goals from different programs, and also considering more of the parsimonious measures that this workgroup has recommended, I think we have a really good universe of measures to choose from to add to the core, so measures like closing the referral loop or medication reconciliation.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
David, this is Paul again. May I just put in a plug, since the Meaningful Use Workgroup is having a hearing concentrating on specialists on May 13th, that this group might want to submit, we're just formulating the questions to pose to the testifiers, so if there are any questions that you would like us to have presented to them, we certainly are open and interested in having those, but it would have to be fairly soon.

**David Lansky – Pacific Business Group on Health – President & CEO**
I wonder, Paul, if we could circulate to this group some version of that hearing agenda so they would know, or the draft questions, so that we could edit and react to that.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
Sure.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
I'll do that.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
Thanks, Judy.

**David Lansky – Pacific Business Group on Health – President & CEO**
Thanks, Judy. Let me ask everybody on the call, other people who want to just comment on how the Stage 1 core menu structure came into being and how well it's working, or any field observations you have about it as a model up to this point. Then we'll talk a little bit about what we need to achieve with the next round. Any other comments on the Stage 1 approach?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
David, this is Jim Walker. As you implement the core, it seems to me that the core could be more universal in its impact than we have made it. BMI is measured from, what, soon after birth through old age, and if we talked about tobacco exposure, which is the real public health problem, then that would be something that screening and intervention would be appropriate probably actually in utero to old age, and immunization status is a critical personal and public health issue again from near birth to old age. And so I don't know if this is an action proposal or just a conceptual proposal, but at least conceptually those three core issues are relevant to almost everybody almost all the time.

**David Lansky – Pacific Business Group on Health – President & CEO**
On the matter of quality assessment, Jim, I'm just taking your point, which is real interesting, but look at the ... continuity of measurement across the lifespan. We have right now this snapshot or transactional model of most of these measures, and we're certainly proposing for Stage 2 to begin with longitudinal measures and trend measures and delta measures, do you have any immediate thoughts, ... do you have

a table of whether some of these biometric indicators over the lifespan should be viewed as quality measures through the literature or case to be made of them as clinical quality measures as distinct from the biometric health status measures?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
Yes, I'm not as clear on that distinction as other people are. Certainly, something like BMI in childhood, there's a trajectory that is meaningful. When it comes to tobacco exposure or immunization status, to me that seems much less a matter of chronology. You need to know what's been done. You need to know the patient's status. And that requires longitudinal information. But it seems to me that the quality measure there is, did you assess tobacco exposure, did you assess immunization status, and even BMI, and then did you do the right thing? If someone's got a high BMI when they're 35, if they had it when they were 17 I don't know that that changes any decision making or any prognosis, maybe prognosis in some subtle way. I'm not quite as clear on the import. We need longitudinal information to do in the moment care, but the trajectory itself is less clear to me, you know, renal failure. There are a few cases where the trajectory, the rate of change affects decision making and care. But I'm not sure I'm clear on how many of those there are.

**David Lansky – Pacific Business Group on Health – President & CEO**
Hold that thought and we'll come back to it when we talk about Stage 2 principles. Let's go back to the Stage 1 review. Any other comments in terms of what you've heard or experienced yourself in terms of people's ability to generate the Stage 1 measures, whether they're working pretty well as a snapshot of HIT sensitive quality improvements?

**Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice**
This is Tripp. As a field tester, so to speak, our practice and across other practices as we participate with LISTSERVs and such, the challenges have been retooling how we do things around the EHR as they have been certified and changed. I think that's going to be a process that will go on forward, but it is certainly a challenge. To Jim's point, I think knowing is half the battle with regard to quality. If you're not measuring BMIs in a practice and you start doing it, then it really does change the quality of the care of the patient, because you know, at least in the office, maybe not necessarily across the population. But it's made a big difference and I think a lot of the practices that I've talked to, and of course Jacob can probably chime in and Neil, but it is starting to make an impact.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
David, this is Paul Tang. One of the challenges I think has been the quality measures, the HR vendors coming up with a consistent way of getting the right data components according to a measures definition and then reporting on that. There is some work, let's say, in NQF still in the early stage of this quality data model where the definitions, they're trying to get more consistent and center those definitions, but that probably is work that still needs to be done. And we have to take that into account and potentially promote the standardization of those data elements. That would make it easier both for the EHR vendors, but also certainly for the providers to have comparable data amongst themselves in their communities and across the board nationally. That, I think has been one of the challenges.

**David Lansky – Pacific Business Group on Health – President & CEO**
Is your observation, Paul, that there has not been adequate standardization of the specifications, even in this first round of measures we need to do better at that?

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
I think that's true, because the source for a data point can be many, and where you capture it can also differ from one setting to another. That's the kind of thing, and sometimes it's little metadata that needs to be defined precisely and standardized and put somewhere, some national repository, so you can go use this same definition. I think that's been challenging with the existing definition, which on the surface may look well-defined, but then when you start trying to implement it, particularly in an EHR, you find out, well, gosh, I might have that piece of data stored in many different places from many different sources. Which one do I use? That's the kind of clarity that's needed if we're going to have comparable data nationwide, which will be important, let's say, for ACOs.

**Josh Seidman – ONC**
This is Josh Seidman. I would agree with Paul on this on the vendor side. This has become a much more difficult process to implement than I think the vendors or we ever anticipated. Just our ambulatory EMR site alone, we're going to have to shut down our database structure for four months to take the meaningful use upgrade, which means we can't add any new physicians, we can't add any new databases to that structure during that time, because it requires that standardized mapping to be redone across the entire board. And on top of that, we've talked to many other customers out there, these vendors that are now talking about not being able to take meaningful use updates for a year out now because they're so backlogged in getting the stuff, so the standards are absolutely great.

The quality measures I think are a little bit more difficult, but not for the actual people doing the work, but rather the IT staff and the vendors to be able to get them standardized and implemented in a way that is usable for everyone else. So we did the right job on the front end for measures, but the implementation side of this and the back side of this is much more difficult than I think most people anticipated.

**David Lansky – Pacific Business Group on Health – President & CEO**
The Standards Committee that we talked about a few minutes ago, the Subcommittee on Local Quality, has put the quality data model as one of its early tests, and one of the things we already started discussing is not repeating this experience; that is, if we could look out to Stage 2 and Stage 3 requirements now, then we could make sure that whatever vendor implementation work getting done right now can accommodate the next two generations of measures without a big structural reengineering project again. So I don't know what the timelines would be realistically for the industry for us to sync up our work with the Standards Committee Subcommittee's work with what the vendors need in this reengineering process, but that's something we should probably take a serious look at.

**Jacob Reider – Allscripts – Chief Medical Informatics Officer**
This is Jacob Reider. I'll echo much of what was just said, especially the comments from Paul about vocabularies. The Standards Committee has looked at value sets, and as most folks know, or many may know, NQF has now published many thousands of value sets that may be used to leverage standardized terms, and I think it's a great start but it's still not there. So I guess I'll echo some of that.

I'd like to add an additional comment that we've recognized in creating quality measure reports for eligible providers, primarily on the ambulatory side, which I think is our context here, is a disconnect between a patient focused view of quality measurement and an EP focused view. The incentive rule is all about incentivizing EPs, and so as we create reports I can look and make sure that Barbara Smith has, from a patient perspective – I shouldn't even pick a real name – Barbara Average Patient, and if Barbara Average Patient has had certain screening procedures done or not done I can make a report that does that and reflects that.

But the question is which EP or EPs have credit for that? That's actually been a huge problem, especially in large multi-specialty groups, deciding how to write a report for a given provider or set of providers. Ideally, this is patient focused, not provider focused. And I think that's a real challenge as we look at this going forward, thinking about what's best from a public health perspective. I think it's a patient focused view, and as long as the patient gets what the patient needs, somehow we need to translate that into how we can generate reports that are reflective of the appropriate use of the technology. That's been a real problem.

**David Lansky – Pacific Business Group on Health – President & CEO**
Other comments about the current experience?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
This is Jim Walker. As implementers we're spending about $500,000 to $750,000 a year on eight senior people to manage this. One of the issues is that even a very robust HIT manufacturer cannot possibly make enough changes fast enough that we can implement them and achieve meaningful use. So we have done a fair amount of both configuration and even custom coding. Our vendor has been hampered

because of two related things, because either they don't have the expertise, or no amount of expertise would enable them to interpret the requirements fast enough and surely enough that they could build with maximum speed, and then some of the requirements have just changed over time. We have had to do a little bit of process change, but other organizations have had to do very extensive process change. And that is the point of all of this, the fact that some organization had software that wouldn't support BMI screening and treatment in the emergency department, that's a good thing that they had to change their process and they implement new health IT to support that, but that is an additional cost.

So, as someone else said, there is really remarkable complexity from the standpoint of the people trying to implement this, and David, you said, which is our goal obviously, is to get enough clarity out there that HIT manufacturers could be building to 2013 and 2015 soon. But that's an intellectually just absolutely daunting task, both on the side of people trying to create measures and the supporting infrastructure that would make that a feasible path, and then on their part to process that and implement it.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
David, it's Paul Tang. I think it's none too early for us to start the chain of events that need to be moving in order to get us measures even for Stage 3. One of the reasons is the measure, right now it's a voluntary process. Someone or group has to decide they want to take up developing, maintaining, and submitting measures, and there's lead time and so we have to cascade the motivation for that to happen. What might happen on this side, the Policy Committee side, is that we make statements saying what kinds of measures we're looking for. It needs to be this very precisely defined quality measure that uses standardized, high quality data elements in its definition. This notion of high quality data elements is something NQF has a definition for, you know, it needs to be easily captured in the EHR, it's captured in the coded, standardized form and so on and so forth. But there's that kind of policy statement we might want to make on this side.

On the HIT Standards Committee side, they need to go into more detail and say, well, not only does the data element have to be standardized in the way it's coded, but you have to decide, as part of the quality measure definition, what's the source and when is it captured. That kind of fine-grain detail is tough work but it will benefit all the folks, whether it's the developers or the implementers that Jim Walker talked about, downstream. Of course the leverage is tremendous when you go across the country.

Then the next step is HHS almost has to contract with measure developers to get some of these things that aren't arising voluntarily, so whether it's specialty measures or functional status or a lot of these experience of care measures, those are things you almost have to go contract for if it's not being developed in the field in a voluntary method. Unfortunately, with the lead time we have to decide when is long enough to wait for the voluntary efforts and then decide some of these things are really important programmatically. Of course with CMS' current direction in value based purchasing they also have both a role and a stake in this.

**Helen Burstin – NQF – Senior VP, Performance Measures**
David, this is Helen Burstin. If I could just follow up on Paul's comment. I do think there are actually some measures, even listed, for example, under Stage 3 that actually are fairly far along, like the delta of the PHT&I, for example, of longitudinal assessment of depression. We recently had our cardiovascular committee meet last week looking at all our measures of blood pressure, for example, and somebody said the next iteration of this measure, when the JNCA comes out in the fall, should include some recognition of home monitoring and bringing in those perspectives. I think some of this is the substrate is there and I think the direction of how to build in some of the key components to the measures, which actually a good number of them exist, could actually take us a fairly long way down that path.

**David Lansky – Pacific Business Group on Health – President & CEO**
Okay, to summarize a couple of things I think we've heard, and we'll just ask for any more comments and then we'll move on to what do we do about it. I've heard that the core measures have worked to a fairly good degree at least in the broad primary care and internal medicine specialties in stimulating more knowing, according to what Jim said, and it's one of our strategies around the whole measurement agenda.

**M**
Hello?

**Tom**
This is Tom .... I wanted to add briefly one other dimension to this, and that is that even if we have data and well specified sources, etc., for a given type of information, like a BMI, for example, we really need to also consider from an incentives point of view what the threshold meaning is, in other words, to get to the meaningful use for incentives, because I think some people are seeing the quality measure as a minimum threshold that has to be cleared to get to actual ... incentives. Then there are other people who are thinking of meaningful use as best practice, in other words, very high threshold, and we have, I don't think done the best job to really get a coherence of messaging around the phrase "meaningful" as opposed to as spelled out into the measure itself. In other words, quality measure still means a lot of different things to a lot of different people. It's a different aspect I think of the standardization discussion, but I think one that we need to tackle from a policy point of view.

**David Lansky – Pacific Business Group on Health – President & CEO**
I'm back. It's David. Sorry about that. So you're saying we should get away from aspiring to the mean?

**Tom**
Yes, because otherwise we will regress to the mean and then it will be very hard to figure out what are the value fiscal implications for the incentives aspect, in other words, the next phase in the discussion. To the extent that we can anticipate some of that now I think would be wiser.

**M**
But isn't the bar the threshold? Right now we just hang on reporting, when they start setting thresholds, isn't that there's opportunity to raise the bar from year-to-year?

**Tom**
Yes, but what I'm saying is I know for a fact that some of the, for example, in HRSA in the HIV/AIDS Bureau they talk about quality measures from the point of view of excellence in practice and best practices. There are other parts of the discussion at HHS which is really thinking of the lowest threshold of minimal quality reached before something would be payable, in other words, either at the measure per individual patient or for a panel or for a population threshold in terms of cancer screening or whatever. So it's still a minimal task approach and I don't know that I've heard enough discussion about whether we mean minimal task threshold or mean or best practice type reach, and so I think there's confusion in the field around what is meant by that actual quality measure, regardless of whether we know the data sources and all that other detail.

**David Lansky – Pacific Business Group on Health – President & CEO**
This is David again. Let me .... I was saying when I got cut off that I think I've heard today some progress on getting information people need to have, we've made some small progress on clinical process improvement, and we're moving toward the outcome goals for Stage 3, so we've had some technical challenges with specification of standards that we need to give more attention to. The burden and challenge for both vendors and implementers is greater than some of us have expected ... going forward, and some question about whether we have a patient focused view or a provider focused view, and how do we make sure the measures go in the upward direction for that.

I guess taking all that into account, let's go back to the structural question of core, alternate core and menu, as Tom described, and if people have any thoughts about, just on a ... if that's the right structure to maintain for Stage 2, or you'd propose any significant re-thinking of that. I think Helen suggested there were some new measures that might help strengthen the core. Any thoughts about the structural template that we're using in keeping with that or not?

**David Baker – Northwestern – Chief, General Internal Medicine Division**

This is David Baker. I like the general structure of the core and the alternate and then the optional ones, but I think our hope should be that we would gradually be able to expand out those core measures, especially for primary care. To do just a few things well is not terribly meaningful for patients. If we're going to take the patient focus we need to have a larger base of core measures.

**David Lansky – Pacific Business Group on Health – President & CEO**
Okay.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
This is Jim Walker. Two thoughts: one, a lot of those core measures are not just primary care, and I think if we're thinking about the patient as the center, there may be a few places, interventional radiology, ophthalmology, dermatology, where some of the core measures, or maybe even all of them, are irrelevant. But think about surgery, for instance, BMI and hypertension and tobacco exposure and immunization status are all critical to that one way and another, and so that's one thing. I think we ought to really quit talking as if primary care was the arena where the core measures are important, because it's just not true clinically.

The second is a policy question. The NQS slide in the slide deck for today, and I think we at some point have said that what we want to do is focus on, again, patients and populations, which would mean we'd focus on remediable burden of illness or some such construct. If that's the case and a specialty doesn't happen to treat anything that rises to a high level of impact in terms of burden of illness, then does it matter that we provide them special measures. I think at least, well, maybe we don't want to have clarity on that, but clarity on that could be useful in some ways, although it could be damaging perhaps politically.

**David Baker – Northwestern – Chief, General Internal Medicine Division**
This is Dave Baker again. Jim, I agree with you that many of these things are applicable across specialties. But I do think that we're going to need to differentiate between core measures for primary care and for others. My concern is if we try to have just a small set of core measures that are applicable across all practices, then we're going to have a very low bar for primary care. Again, if we're going to take the patient centered focus, we have 18 core measures that we routinely report out to all of our physicians that they get quarterly reports on, and the physicians actually want to have more measures. So I think in primary care practices, again, if we're really going to move the needle in terms of health outcomes we need to do a lot of things well, so we may need to have some differentiation in the core measures, or, as you said, it's possible that you could leave it so that some measures were not, for specialties they would just say that they weren't applicable.

The other concern that I have, though, about this is for some of these things, take the example of depression screening, if you say well, that's everybody's responsibility, my concern is that everybody will just check the box off and not really do a good job, or there will be redundancy and confusion. There really needs to be one physician who's really leading responsibility for depression management and following PHQ-9 and I don't think that's something that everybody should be doing.

**Timothy Ferris – Massachusetts General – Medical Director**
This is Tim Ferris. I want to echo what David said and maybe even extend it a bit. I'm a little bit concerned with the application of the principle of parsimony. While it makes a ton of sense in the setting of public reporting, in terms of the work of physicians not only I think is what David said is true about having a common denominator approach resulting in a relatively low bar, but there's also, within the specialties, by not making incentive systems consistent with what the physicians themselves consider their core work, and I can completely get Jim Walker's point about this other work that is very, very important for public health and yes, everyone should be doing it, even if that's not what you generally do, but if we don't have incentives that measure what is their core work, at least the feedback I've gotten here is this is sort of something that really doesn't impact me. They're judging me on this other stuff. And yes, I'll incorporate it and do it, but that's not why people come to see me. So the measurements become, I feel like the parsimony approach leads us down a path where the measurement could be largely irrelevant to a large percentage of the physicians that are subject to this.

**David Lansky – Pacific Business Group on Health – President & CEO**
Let me ask people to react to –

**M**
If I could just respond quickly, I'm not arguing. I think parsimony is a mistaken concept and what I'm arguing is that if we identify the intervention, screening, treatment whatever they are, that we have evidence they will have the biggest impact on individual health, which multiplied by the population is population health, then that would be the key measure. And if you're not somebody who moves that needle forward, then you wouldn't get paid for it, you wouldn't do it. But the issue would be what's best for patients and the population of patients, not what's best for specialties or other practitioners.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**
This is Paul Tang. David Lansky originally asked for some background on the philosophy of the approach, and one of the things that we didn't mention yet is the notion of parsimony. The background for that is there's a difference between a regulation that sets a floor and what individual organizations, all of our healthcare organizations, do to make their care better and to provide information to patients. So on the regulatory side, which is where we are, we wanted to make sure that both the EHR vendors had in place, and not all the EHRs had the ability to report in these easy fashions, so to put in place mechanisms to report easily for the providers and using standard concepts, that's the goal of the required quality measures.

People would then, in our mind, understand the power of this tool not only as a documentation tool, but as one that can both measure and promote continuous improvement of the quality delivered and the experience delivered. So we thought that the market would determine how people use this tool once they have the tools in place to monitor and improve their care. It was not intended to set bars that would drive care and people would only pay attention to these, we wanted to avoid having a big burden that we wanted the tools to be in place to measure and improve care. That's the background in terms of the reason for parsimony. Don't think of it as this is the limit, because I think each organization will decide how to use this powerful tool.

**David Lansky – Pacific Business Group on Health – President & CEO**
One of the issues implied by that, Paul, goes back to the discussion about our vendor challenges. I think it would be unfortunate if every expansion of the scope of measurement required of reengineering of the underlying database by the vendors, this was intended to be a very flexible platform that can support both improvement directed measurement that an organization may want to do and externally required measurements that payers or regulators may want. We have to get to a point where we have a flexible enough reporting platform, and I think part of our job at the policy level is to stress the vendor platforms to the point where they become flexible of generating the kind of reporting ... improvement or external use that is part of, obviously, the policy agenda.

Let me run a model by you and see if people have a reaction, good or bad. Essentially, in the original core, alternate core and menu approach, by introducing alternate core we in a sense ... menu is in the core world of people who are just in the core and people who are in the alternate core. Is it feasible to think of core itself as a menu structure where there are several flavors of core in either a specialty or a practice setting or some other variable that would accommodate the different sense we've all had of some of these working better in some ..., specialties and provider types than others, so maybe the menu stays the menu in this new world with a lot of specialty specific measures that people can choose from that are applicable to their particular area of work. Then core is another kind of menu, maybe less elaborate and varied, but also gives us the fundamental structure of the core within ... you have to choose one of several categories within the core that you want to live in, maybe the surgery and primary care or some broad cuts like that. Do people think this is a workable way to solve this problem, or just stay with the current two part model?

**M**
Are you suggesting a menu core?

**David Lansky – Pacific Business Group on Health – President & CEO**
Yes, because in effect we have a menu core now with two options. You either can satisfy the core as it is, or you move over to the alternate core.

**M**
So you'd have a menu selection of things that you'd be required to have, plus you'd have other options, another menu?

**David Lansky – Pacific Business Group on Health – President & CEO**
Yes. I guess I'm saying your core requirements would itself be something you choose from the menu. I'm in the pediatric core. Or, I'm in the primary care internal medicine core. I'm in the surgery interventional core.

**M**
But then do you also have menus which there's a broad set of measures you can choose for additional measures?

**David Lansky – Pacific Business Group on Health – President & CEO**
I would think so, maybe not. Maybe ... with that. At that point all you have is the menu. I think we all understand the goal of having core cross-cutting high public interest measures, but to Helen's comment, maybe we can stretch the current core farther in the next two time cycles.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
This is Jim. Why not just say these are a set of measures that you can get paid for if you achieve them. Have at it. Then one of the things that would happen in the market is that people might reconsider and say, oh, maybe I should ask about tobacco exposure.

**W**
Well –

**M**
Jim, they're all menu, everything's a menu?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
No. This is longer term but anything that you do you get paid for, and so you don't ask about tobacco exposure, you don't ask about BMI, you don't ask about some ophthalmology thing, you just don't get paid.

**Eva Powell – National Partnership for Women & Families – Director IT**
This is Eva. I'm just wondering, and I certainly don't have an answer here, but I'm just wondering in terms of core measures, I always come back to the notion of care coordination and patient and family engagement as being core concepts that every provider should be able to see themselves in, in some way. I know when you get down to the specific measure level that perhaps there is some differentiation by specialty, but maybe that fits in with David's concept of a menu'd core set. But I feel like we've gotten somewhat mired in disease specific measures, which we probably need to do to some degree, but I would like to see us have at least a number of measures that cut across the things that every provider should be doing in terms of care coordination and patient and family engagement that then will link up to the National Quality Strategy. It just seems like there should be a way to start talking more about how can we design a structure for measurement and specific quality measures that help every discipline see themselves in this National Quality Strategy and their role in helping meet that.

**David Lansky – Pacific Business Group on Health – President & CEO**
That's a great comment, Eva. We talked a year ago about the categories. If you imagine within the core saying everybody has to have at least one measure of care coordination, at least one measure of patient engagement, and maybe they are applied to certain types of practice differently, but that way we would

help to drive these principles we see on our slides, Stage 2 principles, into all meaningful users' practice. If we could find a way to do that, that's very attractive to me.

**Eva Powell – National Partnership for Women & Families – Director IT**
I wonder if that's a way to involve specialty societies offset, and I don't know if this further takes us down the road of your model, David, of having a menu'd core set and additionally another set of menu items from which providers can pick. But it just seems like the specialty societies who right now seem very busy saying how they don't see themselves in meaningful use, if we deliberately structure things in such a way that we bring things up to this level where everyone is trying to meet these goals that we now finally have and then we pitch it to them and say, okay, this is our collective purpose, what is your role in this purpose? And let them tell us and then we create a measure set from that.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
This is Jim. So what we do is we put in the core things that really are core. It's something like communicate with other clinicians and patients about the patient's needs timely. And anyone who doesn't like that one can get up in public and say it. But I would reiterate that most of the ones in the core right now, there are very few people that can make an evidence based case, by the way, which I think we ought to be thinking in terms of, for saying tobacco exposure is not important to my patients and that's not part of my concern, or BMI, or immunization status.

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**
This is Karen Kmetik. Just to throw out another thought for ways to think about the core going forward, and I really appreciate Eva's comments, to also try to send some signals about the HHS national strategies when it comes to particular diseases as well. What I'm getting at is, so in the HHS national strategy that came out we've got a goal of preventing and reducing harm caused by cardiovascular disease, and we've got some illustrative measures listed there in what came out from HHS. To really be able to track as a nation how we're doing there, on those measures we've got to get to standardization, as Paul Tang and others have said.

So is there an opportunity also, and I don't know if meaningful use is the place, but to say among the core it's all of what Eva described, but it's also in this area where we said as a nation we want to focus for a period of time, we're also looking for standardized data elements, standardized data entry, is there a way to add more specificity, as Paul said, but to emphasize that that's an area where we want to get to, confidence in data, comparability, national tracking. Whereas, the menu option gives you what individual practice sites need to do something that's relevant to the ... population.

**David Lansky – Pacific Business Group on Health – President & CEO**
Okay. Other thoughts about this structure? This may be a good time to look briefly, in case you haven't already, at the National Quality Strategy elements and think a little bit about how these might map into this discussion we're having now. I don't know if, Tom, you want to do a quick update on that? It's the next slide.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
This is Jim. I'd just like to highlight, if we really focus on evidence based healthcare, that would change the discussion from specialty saying there's nothing there that we like, to making a different kind of argument, and then things like care coordination and communication and all of that become much more obviously core. As long as it's sort of "I don't like that," we're not going to get anywhere.

**Helen Burstin – NQF – Senior VP, Performance Measures**
Yes. This is Helen. There are certain aspects, certainly of patient and family engagement and care coordination, I agree with David, that certainly fit in the core. It's hard to imagine anybody could say that care experience, closing the referral loop, patient experience of care are not core to all of us regardless of specialty, and perhaps one way to do this is to pull into core a couple of those key dimensions in the quality strategy and populate those.

**David Lansky – Pacific Business Group on Health – President & CEO**

Right. Does anybody need any additional looking at the National Quality Strategy slide that I think is on our screen now? It's a little blurry, but hopefully you've all had a chance to look at the primary document.

**M**
Just to raise again the talks about leading causes of mortality but not about specialty interest.

**W**
Right.

**David Lansky – Pacific Business Group on Health – President & CEO**
The next slide, if we have it, just pulls out those priorities for a little more explicit visibility, and you'll see the frequent focus on cardiovascular disease is a national strategy that you may want to pay attention to. But certainly these domains that Eva teed up could be easily brought into the core, at least ... and we'd have to think about how to operationalize that.

**M**
One thought, David, like with the cardiovascular, being sensitive to the different shapes that can take so that any patient being prepared for practically any surgery ought to have cardiovascular risk assessed using a clinical prediction rule. That's part of this, is really seeing it from the patient's standpoint, all the way from average risk screening to management of all of your issues in view of that particular issue.

**David Lansky – Pacific Business Group on Health – President & CEO**
Any other thoughts, reactions, solutions how we might re-work the core to take advantage of this emerging national set of priorities and the experience we've all had so far with Stage 1?

**Jacob Reider – Allscripts – Chief Medical Informatics Officer**
This is Jacob. I'd like to scratch my chin a bit. Do we have a window of a couple of days where we can throw ideas at you, David?

**David Lansky – Pacific Business Group on Health – President & CEO**
Absolutely, yes. I think we're going to come back to this. One question we should also talk about, we do have, as Paul said, the specialist hearing coming up in May, and I see Judy has already sent around the invitation to us to add to the list of questions for the specialists. There's been some suggestion, do we need a hearing or some kind of testimony on the Stage 1 implementation experience with these measures, or even from our quick conversation today do we have enough of a sense of experience in the field, and do you all have any, and this is something, Jim, our two subcommittees could do jointly if we want to hear both some of the technical experience of vendors and implementers as well as more the policy and clinical improvement experience, what do people think about trying to get more input about the Stage 1 experience thus far before we go much further on the Stage 2 design?

**Joachim Roski – Engelberg Center for Health Care Reform – Research Director**
David, this is Joachim Roski. I actually think that would be very useful for us to better understand how clinicians and organizations are responding and have a more nuanced understanding about what these regulations have meant for positions in small practices, organizations such as Geisinger, which we've already heard about, and anything in between to better understand what the, "level of enthusiasm" might not be quite the right words, but to what extent physicians are participating. Because I would be concerned that if we devise a program that physicians essentially check out of or don't feel they have something in it for them, that we might engage in some theoretical discussion. So I wonder, Tom, if you have any insights into by what time CMS or you guys will have a formal or more informal understanding about participation rates, who is participating, and being able to characterize what that looks like?

**Tom**
Joachim, I think we're going to get some evaluation data in probably by the first quarter of next year, at least on the Stage 1. Providers have the ability to attest until the very end of this year and we're trying to collect at least some data from an advanced vanguard group of doctors and implementers and folks who are planning on attesting to meaningful use over the course of the next six to eight months, so probably

not until sometime in the beginning of 2012 to actually look at the granularity of data that would be informative in terms of core versus menu measures and what works and what doesn't work in terms of relevancy in their practice.

**Joachim Roski – Engelberg Center for Health Care Reform – Research Director**
Yes, I'm certainly going to be mindful of the issue of the clock that's ticking, that you've got to work on the general infrastructure even if you don't know what the uptick is, so that you could move forward if things are a go. But I'm also mindful of a potential gap that could occur between a very advanced system that's being developed and non-participation in .... I'm afraid I don't really have a solution other than to just state the obvious.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**
This is Jim. To respond to your question, David, that would be a spectacular thing to do it together. I have been putting together an informal poll for the committee, but I think it would be great to do it together. I think we probably need to identify informants and get something out to them quick. Our workgroup's timeline is to be done with this by May as a prelude to doing the work on 2 and 3 so that we can report to the Standards Committee, I guess it is August. We've tried very hard in the workgroup, as you know, to create a rational timeline that includes the time it takes HIT manufacturers and the time it takes implementers to actually implement, and to give them any kind of honest chance at MU 2 we're going to have to do it very fast, but I think we can. It won't be as fine-grained as what comes out next year, but we've got to do it.

**Russ Branzell – Poudre Valley Health System – CIO**
This is Russ. I'd be very careful, though, about going out and asking for a whole lot of feedback on Stage 1, mainly because I think people are divided generally in two camps. There are those that are just going to complain and whine about it no matter what, and then there are those that are doing everything they humanly can to get down this path because it's the right thing to do and are working towards it, and as long as we are very selective on who we get the feedback from, to make sure it's actually additive to the process. If not, if we go out for general feedback we're going to just get a whole lot more disintegrated information that's not going to necessarily help us too much.

**M**
I totally agree. I think that's a great point. Yes, at least in my mind we're picking people who are astute enough to know and frank enough to tell us good, bad and not just whine at us. So people that the group is aware of who is that kind of people, please send it to David or me. I think this obviously has to be a fairly select group and a fairly fast whack at it.

**David Lansky – Pacific Business Group on Health – President & CEO**
I think we certainly want to balance a report from the community of both people who are seeing the potential and the advantages of going down this path that are supportive of it and give us good input, and people who may have very legitimate cautions and concerns they want to share. We don't want to have a tale of woe all day, so I appreciate your suggestion.

I do have a date, just so everyone knows May 19th is being held off, Judy reminds us, as a potential date for a public meeting on our schedule. I don't know how it works with the Standards group. So it is, in terms of calendaring, feasible to do something in mid-May if we can quickly identify the right kinds of people to bring up their experience.

**Joachim Roski – Engelberg Center for Health Care Reform – Research Director**
David, this is Joachim. Do we know anything about researchers in the field who might currently already be engaged in some surveying efforts, for example, ... conducted in the annual survey that is in this general area. If anybody has any knowledge about that and information we might be able to tap into that's collected already in a systematic way, that might be useful.

**M**
I'd also suggest talking to the Center for Health Systems Change. They may be looking at this.

**David Lansky – Pacific Business Group on Health – President & CEO**
So far I've heard with some caution for balance encouragement that this is a worthwhile idea to pursue. Any other strong feelings for or against going down this road, some kind of public input process?

**M**
I should probably frame this. I think from the workgroup's standpoint this is not about reasons not to do this, it's just any potholes anybody's fallen into that we can pave for MU 2 and 3. It's not as if this is a referendum on MU 1 or MU in general. If we get a heavy emphasis on problems, that's actually what we want, and it doesn't mean that we're going to change what we do based on what we hear, just that we make sure that we haven't missed any potholes that we can keep people from falling into.

**David Lansky – Pacific Business Group on Health – President & CEO**
So let's recap. We can explore quickly to see if we can do a public hearing on some of these issues and make sure we sharpen our understanding of the challenges of implementation. We've had some discussion about how to re-think the core menu approach and perhaps bring in some of the themes from the National Quality Strategy and Stage 2 principles into a core redesign. We haven't talked much about the menu. Does anybody have any comments they just want to share at this early stage about how we think about the menu and bringing the retooled measures and the measure concept that are out for development now into the menu approach that particularly the specialties are addressing?

**David Baker – Northwestern – Chief, General Internal Medicine Division**
This is David Baker. I think we should conceptualize the core measures. First, I want to say, somebody said a phrase before that I think was very important, was "improvement directed measurement." And it's important for us to recognize that if the goal is quality improvement you can't improve everything at once. So if we start off with these core measures, then I think we should view the menu sets as saying, okay, we want everybody to be pushing the edge and continually be trying to take on some new messages, which gets to this concept of gradually expanding out the core measures but not overwhelming providers and not overwhelming groups' ability to do quality improvement projects, but gradually expand out the core set and view the menu set as new initiatives for groups to undertake.

**Eva Powell – National Partnership for Women & Families – Director IT**
This is Eva. I would totally agree with that. And that also gives flexibility to providers to identify those areas that for them are areas for particular attention for improvement, because obviously some providers do better in some areas than others and that can be a means of customizing to their particular improvement needs. And I wonder if part of this whole process, menu versus core, obviously core should point to the National Quality Strategy, but I don't know why we would have really any measure, even in the menu set, that didn't have some link to getting us to achieving the National Quality Strategy. So it might be useful at some point to have the crosswalk of the various measure options that were there in Stage 1, but also the ones we're considering for Stage 2, and just make sure that whatever we're talking about has a clear link to the National Quality Strategy. Otherwise, I'm not sure why we would include it.

**David Lansky – Pacific Business Group on Health – President & CEO**
I just want to add one other dimension to this, appreciating David's comments, that the purpose of the quality measures is not only to stimulate the use of the IT platform for internal improvement and redesign, but also we want these to sync up with the many uses of quality measurement by external parties for payment and recognition and public reporting and so on. So I know NQF work will be going forward with developing some criteria for measure selection for purposes of ... public reporting, and I think the ideal state would be some alignment or convergence between the uses of the measures for internal improvement support and this infrastructure that will continue to be needed to help with payment reform and other uses of the data. So part of our job, I think, is to balance, Congress originally in HITECH envisioned these multiple objectives ... enterprise, and part of our job is to make sure that the infrastructure supports both.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**

David, this is Paul. I thought there was also a notion of combining your menu'd four approach with Eva's approach of making it so everyone would select some from the menu of the four categories that reflect the principles, you know, the care coordination of public health, the quality ..., etc.

**David Lansky – Pacific Business Group on Health – President & CEO**
Yes, I like that idea as well. I think a couple of people have spoken to it. When I mentioned re-thinking the structure of the core, that's one of the options I think we should take seriously, and maybe ask the ONC staff to take a look at.

Let me go back to Tom at this point and see, Tom, if we've covered the major issues that were front and center for you today and anything else either you want to come up today or what you think our next couple of steps should be up until our next meeting, and then this consideration of this hearing that we've been discussing.

**Tom**
I think this is an incredibly productive conversation and we have the easy job of taking your recommendations and balancing it with the other 50 or 40 other demands or asks across the HHS as well as other public stakeholders. So I think this is not the final end product. I think the conversation would go on to the next two of the meetings at least. I'm wondering if we covered the issue of the hearing, David?

**David Lansky – Pacific Business Group on Health – President & CEO**
What I've heard is a consensus, I think –

**Tom**
Or having a joint hearing with the Clinical Quality Workgroup.

**David Lansky – Pacific Business Group on Health – President & CEO**
Yes, and ideally May 19th may be the date for that if all the stars align and if we can get busy in the next week or so with identifying good candidates to bring us testimony, but ask the committee as a whole if anyone feels differently about that ...? I heard general support for it, besides the concerns that were voiced by a couple of us about ensuring we have the right balance, is there any other hesitation about going forward with ...?

**Tom**
I really like Eva's idea with the notion of having the five principles at least contained in the core represented by notions of measures within the core. I think that's a really good start.

**David Lansky – Pacific Business Group on Health – President & CEO**
Good. Tom, besides this hearing, if we can pull it together, our next meeting, do you have any idea when we meet again by –

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Yes, it's May 5th, David.

**David Lansky – Pacific Business Group on Health – President & CEO**
So at that point we can maybe take our own look at the kinds of questions we want to put to our witnesses for the May 19th event, if that's what it is. And what's our next topic on that May 5th meeting, Tom?

**Tom**
Perhaps the ONC staff can help out with creating a straw man of the Stage 2 principles embedded within the core. Then the committee members can actually fill in the straw man.

**David Lansky – Pacific Business Group on Health – President & CEO**
All right, let me see if there are any last words and then we'll do public comment. Any other comments from the group? I thank you all for a really wonderful discussion. I think we moved the ball very quickly

due to your effort today. Thanks very much for your creative thinking. Let's see, Judy, if we have any public comment.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Operator, can you please check with the public?

**Operator**
We do not have any comment at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Thank you, operator. Thank you, everybody.

**David Lansky – Pacific Business Group on Health – President & CEO**
Thanks, everyone.